

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in place of item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 406 11/6/68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14316										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)										2a. DATE KNOWN OF DEATH									
First Middle Last EDWARD WILSON AULD, Jr.										Month Day Year Oct. 24, 1968									
3. SEX Male										2b. HOUR 2:00 P									
4. RACE White										2c. DATE PRONOUNCED DEAD									
5. DATE OF BIRTH Nov 25, 1911										Month Day Year Oct. 24, 1968									
6. AGE (In years last birthday) 56 YRS.										2d. HOUR 2:00 P									
7a. BIRTHPLACE (State or foreign country) Md										7b. CITIZEN OF WHAT COUNTRY? U S A									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Charles									
10. CITY OR TOWN OF DEATH Benedict										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Huntt Funeral Home									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired fireman										12b. KIND OF BUSINESS OR INDUSTRY D C									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Charles									
13c. CITY OR TOWN Benedict										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e. STREET AND NUMBER Post office box #85																			
14. FATHER'S NAME First Middle Last Edward Wilson Auld sr										15. MOTHER'S MAIDEN NAME First Middle Last Henrietta Hilseberg									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes										16b. SOCIAL SECURITY NO. 219 01 3693									
17. INFORMANT ADDRESS Florence I Auld Benedict, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 9299																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year 7:30 P.M. 10-22-1968									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Drowning																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ??									
21f. LOCATION Street or R.F.D. No. ??										City or Town Benedict County Charles State M.D.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)									
22b. DATE SIGNED October 25, 1968																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Oct 28, 1968									
23c. NAME OF CEMETERY OR CREMATOR Baltimore National										23d. LOCATION (City or Town) (County) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR F. Gasch's Sons										ADDRESS Hyattsville, Md.									
25a. REC'D BY REGISTRAR DATE OCT 28 1968										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

14832

MEDICAL EXAMINER, CERTIFICATE OF DEATH

1961

NEW YORK

CITY OF NEW YORK



OCT 28 1961

Frank J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14317									
14326									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH		2b. HOUR	
CATHERINE SWANN BOWLING						Oct Month 23 Day 1968 Year		8:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		WHITE		Sept. 27, 1904		64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MD		U.S.A.				Charles			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
LA PLATA		Physicians Memorial Hospital		Domestic Housewife					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Charles		WICOMICO					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Smith			EUNICE SWANN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO						R. P. BOWLING JR. - CHARLOTTE HALL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4319 CUA DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Aorta Central artery DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 43 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 332X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arthur C. Woody, M.D.						22c. DATE SIGNED 24 Oct 68			
22d. PHYSICIAN'S NAME (Type) ARTHUR C. WOODY, M.D.						22e. ADDRESS LA PLATA, MARYLAND, 20646.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-26-68		Dentsville Methodist		Dentsville Charles MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUNT Funeral Home				Waldorf, MD		OCT 28 1968		Charles Judge	

14386

14386

14386

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14318

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14327

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print) <b>Floyd Lee Butler</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10-6-68</b> Year <b>1968</b>		2b. HOUR <b>1PM</b>	
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>10-23-48</b>	6. AGE (In years last birthday) <b>19</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN. _____
7a. BIRTHPLACE (State or foreign country) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>D.C. USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>LaPlata Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial LaPlata Md</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Aquasco</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Aquasco</b>	
14. FATHER'S NAME <b>Joseph D Butler</b>		15. MOTHER'S MAIDEN NAME <b>Mildred Hardy</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>John L. Butler-Aquasco Md.</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination due to laceration of spleen</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 Hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>825.4</b>					
19a. DATE OF OPERATION <b>10-6-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Left Arm</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>2-AM</b> <b>10-5-68</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>		21f. LOCATION Street or R.F.D. No. City or Town County <b>Ches.</b> State <b>Glasva-Intersection Rts. 234 &amp; 301 Md.</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James E. Andrews MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>1-7-68</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Church Cem. Broadview, P. Geo. Md.</b>	
24. FUNERAL DIRECTOR <b>Marcel Adams Aquasco, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

14381

THE UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

1931

FOR STATE  
HEALTH DEPT

1931



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### 14319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14328

1. DECEASED NAME (Type or Print) First Middle Last <i>Reache A CARROLL</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <i>10 5 1968</i>			2b. HOUR OF DEATH <i>10 5 1968</i>											
3. SEX <i>M</i>		4. RACE <i>C</i>		5. DATE OF BIRTH <i>8-27-02-66</i>		6. AGE (In years last birthday) <i>66</i> YRS.		7. UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		8. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <i>19</i>			2d. HOUR <i>M</i>		
7a. BIRTHPLACE (State or foreign country) <i>Ind</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Charles</i>								
10. CITY OR TOWN OF DEATH <i>Lafayette</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview Hosp.</i>						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Ind</i>			13b. COUNTY <i>Charles</i>			13c. CITY OR TOWN <i>McVictoria</i>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER					
14. FATHER'S NAME First Middle Last <i>John Henry Carroll</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Bettie D. Thomas</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>1214-12-783</i>			17. INFORMANT <i>Mrs Odessa Carroll</i>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occ.</i> <i>884X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Heart, Tr</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-5-68</i> <i>9-23-68</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Heart, Tr 8-2-3-68</i>																	
19a. DATE OF OPERATION <i>9-2-1</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>8-23-68</i> P.M. <i>1</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell from beam</i>									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>				21f. LOCATION Street or R.F.D. No. City or Town County State <i>McVictoria Charles Ind</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>E. J. DeLeon</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>2-13-69</i>					
EXAMINER'S NAME (Type) <i>E. J. DeLeon</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-9-68</i>				23b. DATE <i>10-9-68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Shiloh Church Co. Charles Co. Ind</i>				23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <i>Marcelo Adams</i>				ADDRESS <i>Quincy</i>				25a. REC'D BY REGISTRAR <i>FEB 20 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

585

THE NATIONAL BUREAU OF STANDARDS  
WASHINGTON, D. C. 20540

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14320

14329

1. DECEASED-NAME (Type or Print) <b>FERN</b>		First <b>ARLENE</b>		Middle <b>CLEARY</b>		Last		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Oct. 14, 1968</b>		2b. HOUR <b>5:30 P</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 24, 1933</b>		6. AGE (In years last birthday) <b>34</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <b>Oct.</b> Day <b>14,</b> Year <b>1968</b>		2d. HOUR <b>5:30 P</b>
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b>					
10. CITY OR TOWN OF DEATH <b>Laplate</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Laplate Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERICAL</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Laplate</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD</b>			
14. FATHER'S NAME <b>PETER</b>		First <b>L. WHEELER</b>		Middle		Last		15. MOTHER'S MAIDEN NAME <b>SADIE</b>		First <b>J. WRIGHT</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-30-2280</b>		17. INFORMANT <b>JAMES M. CLEARY JR., LAPLATA, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b> <b>398X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>416X</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>October 15, 1968</b>			
EXAMINER'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEM. GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>WALDORF, CHARLES, MD.</b>		24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME, WALDORF, MD.</b>	
		25a. REC'D BY REGISTRAR DATE <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14322

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Signature]*

800 83500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 574  
30M REV 1/68

14321										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14330																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
James Arthur Dudley										Oct Month 11 Day 1968										6:30 A M																																							
3. SEX Male										4. RACE Caucasian										5. DATE OF BIRTH Feb. 29, 1888										6. AGE (In years last birthday) 80										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH Charles										Md.																			
10. CITY OR TOWN OF DEATH La Plata										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Mem. Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter										12b. KIND OF BUSINESS OR INDUSTRY Building																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Charles										13c. CITY OR TOWN Ironsides										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
14. FATHER'S NAME William H. Dudley										15. MOTHER'S MAIDEN NAME Catherine L. Tolson										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No										16b. SOCIAL SECURITY NO. 216-18-5047A										17. INFORMANT Perry Hall, Mr. Daniel O. Dudley-Son										Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2-3 days</u> <u>Years</u>																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS, CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>7 Oct</u> , 19 <u>68</u> , to <u>11 Oct</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>10 Oct</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>J.B. Mason M.D.</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>14 Oct 68</u>																																							
22d. PHYSICIAN'S NAME (Type) <u>J.B. Barry Mason, M.D.</u>										22e. ADDRESS <u>La Plata, Maryland</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE <u>10/14/1968</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Pisgah Methodist Cemetery, Pisgah, Maryland</u>										23d. LOCATION (City or Town) (County) (State) <u>Pisgah, Maryland</u>																													
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc. - La Plata, Md.</u>										ADDRESS										25a. REC'D BY REGISTRAR DATE <u>OCT 16 1968</u>										25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>																													

14838

RECORDS OF DEATH

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Age

1901-1902

Charles

U.S.A.

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Physician, Wm. Hospital, Vancouver

in 1914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14322		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14331			
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
BABY		BOY	EDELEN		October 4, 1968		? M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS	
Male		Negro		October 4, 1968		YRS.		30	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Charles			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of last year, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
La Plata		Physicians Memorial Hosp.		Infant					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Charles		Rock Point					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Charles Edelen					Martha Corona Edelen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		None		Margaret R. Edelen-Aunt-Rock Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 777 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 776 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (H) (this hospital) attended the deceased from <u>4004</u> , 19 <u>68</u> , to <u>4004</u> , 19 <u>68</u> , that (H) (we) lost the deceased alive on <u>4004</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		J.B. Masson M.D.				22c. DATE SIGNED		400468	
22d. PHYSICIAN'S NAME (Type)		J.B. Masson, M.D.				22e. ADDRESS		La Plata, Maryland	
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/5/1968		Holy Ghost Cemetery		Issue, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arehart Funeral Home, Inc.-La Plata, Md.				DATE OCT 10 1968		J. Charles Judge			



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# FOR STATE HEALTH DEPT.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14332

1. DECEASED-NAME (Type or Print)		First CHARLES		Middle BENJAMIN		Last GWYNN		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 10-19 1968		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 27, 1895		6. AGE (In years last birthday) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year October 19, 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARLES				2d. HOUR 7:00 P. M.	
10. CITY OR TOWN OF DEATH Cobb Island		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant Owner		12b. KIND OF BUSINESS OR INDUSTRY Retirer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Cobb Island		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Louis Gwynn				15. MOTHER'S MAIDEN NAME First Middle Last Lucetta Hayden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year and dates of service) WW 11		16b. SOCIAL SECURITY NO. 217-30-0382		17. INFORMANT Mrs. Dorothy E. Gwynn-Wife,		ADDRESS Cobb Island, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive neoplasm involving right axilla with terminal hemorrhage 2399 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 239X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED October 20, 1968		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/23/1968		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City or Town) (County) (State) Wayside, Maryland					
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.				ADDRESS		25a. REC'D BY REGISTRAR OCT 23 1968		25b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14332

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

FOR THE  
DIRECTOR

TO :	FROM :
SUBJECT :	RE :
DATE :	FILE :
BY :	CLASS :
APPROVED :	REVIEWED :
SPECIAL AGENT IN CHARGE	SPECIAL AGENT IN CHARGE

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

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100. [Illegible text]

14324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-508. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
James Henderson								10-4-1968		10		4		19		4-PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	3-12-1926		42 YRS.		MONTHS		DAYS		10-4-68		10		4		19	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Georgia		USA		WIDOWED		DIVORCED		Charles County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
LaPlata Md		Physicians Memorial		Laborer		011											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Georgia		Schols Co.		Seacoville		YES		NO									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
F.M. Henderson								Elizabeth Padgett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes-US. Navy		11-11-11		260-34-3017		Walter Henderson-Brother		405 Audrey Lane								Oxen Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Pulmonary congestion and edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		6-Hours							
8199		DUE TO, OR AS A CONSEQUENCE OF		(b)		Fracture and dislocation of cervical vertebrae		35-Hours									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		(c)		Automobile accident		35-Hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		8254															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
10-2-68		Fracture & Dislocation of cervical Vertebrae		YES		NO											
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
PRIMARY		12:30 PM		Auto Accident		WHILE AT WORK		Highway		Bryans Road Md		Charles County					
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22b. DATE SIGNED		10-5-68															
ACTUAL SIGNATURE		James E. Andrews		M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)		Indian Head, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		10/8/1968		Statenville Cemetery		Statenville, Georgia											
24a. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Reid Funeral Home, Inc.		La Plata, Md.		OCT 10 1968		Charles Judge											

14833

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH  
PLACE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of attending physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of mortuary		17. Signature of embalmer		18. Signature of casket	
19. Signature of coffin		20. Signature of shroud		21. Signature of burial	
22. Signature of interment		23. Signature of cremation		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	

14833

14833

14833



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14325

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14334

1. DECEASED-NAME (Type or Print) <b>SANDRA Kaye HOLLEY</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>10:10</b> AM		
3. SEX <b>F</b>	4. RACE <b>C</b>	5. DATE OF BIRTH <b>2-27-54</b>	6. AGE (in years last birthday) <b>14</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>14</b>	IF UNDER 24 HRS. HOURS <b>10</b> MIN <b>10</b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>16</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b> Md.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Student</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Wheaton</b>		
14. FATHER'S NAME First <b>Robert A.</b> Middle <b>Holley</b> Last <b>Holley</b>			15. MOTHER'S MAIDEN NAME First <b>Elizabeth B.</b> Middle <b>Blume</b> Last <b>Blume</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Father</b> ADDRESS <b>Same as Item 13.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hemorrhage and</b> <b>816.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Multiple trauma to</b> (b) <b>Multiple trauma to</b> DUE TO, OR AS A CONSEQUENCE OF <b>chest auto accident</b> (c) <b>chest auto accident</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-16-68</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8234</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE-WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>10-16-68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Car accident</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>			21f. LOCATION Street, or R.F.D. No. <b>1000</b> City or Town <b>La Plata</b> County <b>Montgomery</b> State <b>Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>[Signature]</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-17-68</b>		
EXAMINER'S NAME (Type) <b>E. J. PUMPHREY</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <b>La Plata, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-30-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>			23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>			25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		
			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

14334

EXHIBIT 1000-1-1000

1000-1-1000



EXHIBIT 1000-1-1000

EXHIBIT 1000-1-1000

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EXHIBIT 1000-1-1000

EXHIBIT 1000-1-1000

EXHIBIT 1000-1-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 151  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14326					14335								
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR					
Arthur W. Jeter					Month Day Year OCT. 4, 1968			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
Male		White		Aug. 27, 1918		50							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN					
Va.		USA				Charles		Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
La Plata			Physicians Memorial			Truck Driver			TRUCKING				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md			Charles			Port Tobacco							
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last								
Wm. Jeter					Eva Blackburn Jeter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
No			223-05-0566		Lillian Sidler-La Plata, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, Cause not known</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver &amp; Hepatic Coma</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>581.0</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31, 1968</u> , to <u>10/4, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>N. Bhaduri</u> M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/5/68</u>						
22d. PHYSICIAN'S NAME (Type) Niren N. Bhaduri					22e. ADDRESS WALDORF, MD. 20601								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)		
Burial		10-7-68		Nanjemoy Baptist			Nanjemoy Charles		Md.				
24. FUNERAL DIRECTOR Hunt Funeral Home Waldorf, Ma.					25a. REC'D BY REGISTRAR DATE		OCT 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

14332

1123

Arthur J. Jelen

Mr. Jelen, 1000 N. 1st St., St. Paul, Minn.

Dear Mr. Jelen:

I am writing you regarding the

Charitable Port Tobacco

and the various other matters

which are of interest to you.

✓

Respectfully,  
Arthur J. Jelen

Printed 10-1-58

Printed 10-1-58

OCT 10 1958

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>James Preston Jones</b>										2a. DATE KNOWN OF DEATH <b>10-5-68</b>		2b. HOUR <b>8-AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>9/25/47</b>		6. AGE (In years birthday) <b>21</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>10-5-68</b> Day Year <b>19</b> 8AM	
7a. BIRTHPLACE (State or foreign country) <b>Charles Co.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Charles</b> Md.				
10. CITY OR TOWN OF DEATH <b>Glasva Md</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 301</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Construction</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Pr. George</b>				13c. CITY OR TOWN <b>Aquasco</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>Robert Theodore Jones</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Virginia Wills</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>Aunt, Agnes L Savoy Aquasco, Md. 20608</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Injuries Multiple Extream</b>												<b>Immediate</b>	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <b>Auto Accident</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8254</b>													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year <b>10-5-68</b> HOUR A.M. <b>1:30AM</b> P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Rt-301-Glasva Md.</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rt-301-Glasva Md. Charles County Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>James E. Andrews MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>10-5-68</b>					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>10/9/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Brompton Brompton, Charles, Md.</b>				23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Marcell Adams Aquasco, MD</b>				ADDRESS				25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



802 11 750

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14328

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14337

1. DECEASED-NAME (Type or Print)		First MELVIN	Middle JOSEPH	Lost KERSEY SR.	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-6 1968		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH FEB. 15, 1918	6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month October Day 6, Year 1968	2d. HOUR 8:00 A.M.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CHARLES Md.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY N.O.S.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First THOMAS		Middle V. KERSEY		15. MOTHER'S MAIDEN NAME First MARGARET		Middle SCOTT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WWII 212-03-8649		17. INFORMANT ADDRESS MARY R. KERSEY, LA PLATA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple blunt injuries 815.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8194							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 3:00 PM 10-6 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in auto-fixed object collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) highway		21f. LOCATION Street or R.F.D. No. Rt. #225		City or Town Ripley County CHARLES State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED October 7, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-9-68		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) LA PLATA, CHARLES, MD.	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.				25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARTLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14329										
14338										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First JOSEPH		Middle EDWARD		Last MARTIN		2a. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1968</u>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 19, 1923			6. AGE (In years lost birthday) 45 YRS.		2b. HOUR 2 P. M.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Charles Md.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicans Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Transport-Chauffer Truck			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before omission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Faulkner		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Stop		
14. FATHER'S NAME First Raphael			Middle H. Martin		Last Rose A. Mc Gee		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give dates of service) WWII			16b. SOCIAL SECURITY NO. 220-26-6796		17. INFORMANT Address Lucy Estelle Martin-Wife-Faulkner, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram neg. Septicemia</u> <u>566X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>perineal abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 weeks</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>576X</u> <u>diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-3</u> , 19 <u>68</u> , to <u>10-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-9-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>F. M. JOHANSON M.D.</u>		22e. ADDRESS <u>LA PLATA, Md.</u>								
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE <u>10/10/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Clinton, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Arehart Funeral Home, Inc.-La Plata, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

Casey, 1996, 2001, 2003.

• • •

1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.

1911-12-13, 1912-13, 1913-14

Figure 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14330

CERTIFICATE OF DEATH

14339

1. DECEASED-NAME (Type or print) <b>Baby Boy</b>			Middle <b>Neale</b>			Lost			2a. DATE OF DEATH Month <b>Oct</b> Day <b>6</b> Year <b>'68</b>			2b. HOUR <b>12:10 PM</b>		
3. SEX <b>Male</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>10/6/68</b>			6. AGE (In years last birthday) <b>—</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS <b>7</b> <b>30</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Charles</b>			Md.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hospital Physicians Memorial XXX</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Infant</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md. La Plata</b>			13b. COUNTY <b>Charles</b>			13c. CITY OR TOWN <b>La Plata</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>NORMAN JOSEPH</b> Middle <b>WOODLAND</b> Last			15. MOTHER'S MAIDEN NAME First <b>Ina</b> Middle <b>Paulette</b> Last <b>Neale</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>James E. Neal-Grandfather-La Plata, Md</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>777x Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>776x</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Oct</b> , 19 <b>68</b> , to <b>6 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6 Oct</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>J.B.B. Masson</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6 Oct 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>J.B.B. Masson, M.D.</b>			22e. ADDRESS <b>La Plata, Maryland</b>											
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>			23b. DATE <b>10/8/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>La Plata, Maryland</b>					
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>OCT 10 1968</b>			25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>					

12882

RECEIVED

12882



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPT. OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>MABEL VIRGINIA Percival</b>					2a. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>9A</b> M	
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 5, 1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b> Md			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Palmer Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8406 Sheriff Rd.</b>	
14. FATHER'S NAME First Middle Last <b>JOHN PROBST</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZABETH JAMES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>James Percival New Preston, Conn.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>472X</b> IMMEDIATE CAUSE (a) <b>Lobar Pneumonia Rt</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(D) Pneumothorax</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary emphysema</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5271</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>10/26/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>N. Bhaduri M.D.</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/26/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>N. Bhaduri M.D.</b>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geo. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14341

1. DECEASED NAME (Type or Print) <b>Rosie Lee Posey</b>			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>6:PM</b>			
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>8-17-1945</b>	6. AGE (In years last birthday) <b>23</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>20</b> Year <b>1968</b>			2d. HOUR <b>6PM</b>			
7a. BIRTHPLACE (State or foreign) <b>Hilltop Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles County Md.</b>						
10. CITY OR TOWN OF DEATH <b>LaPlata Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial LaPlata Md.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>US.Govt</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Grayton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME <b>Richard M. Proctor</b>			First Middle Lost			15. MOTHER'S MAIDEN NAME <b>Alice Key</b>			First Middle Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-42-8538</b>		17. INFORMANT <b>Marie C. Ford-Sister Indian Head Md.</b>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>819.9</b> (b) <b>Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8254</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>6:PM-10-20-68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway-225</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Near Ironsides Md. Charles Md</b>								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>James E. Andrews MD</b>			EXAMINER'S NAME (Type) <b>James E. Andrews MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-21-68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Bapt. Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Charles Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Montgomery Bros. 719 Kennedy St. NW</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>OCT 25 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



14341

RECEIVED BY THE AIR FORCE  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

14341 288 1000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

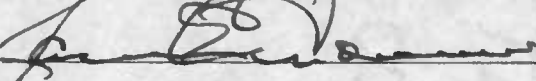
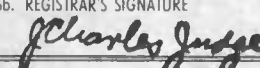
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14333

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14342

1. DECEASED-NAME (Type or Print) <b>xProctorx Alice Proctor</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>6:30 P.M.</b>		
3. SEX <b>F</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>7-30-1919</b>	6. AGE (In years last birthday) <b>49</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>20</b> Year <b>1968</b>		2d. HOUR <b>6:30 P.M.</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles County</b>		
10. CITY OR TOWN OF DEATH <b>LaPlata Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physician Memorial LaPlata Md House-wife</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ironsides Md</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Ironsides</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First <b>Agusta</b> Middle <b>Key</b> Last <b>Key</b>			15. MOTHER'S MAIDEN NAME First <b>Marie C-Ford</b> Middle <b>Daughter</b> Last <b>Indian Head Md.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Marie C-Ford-Daughter Indian Head Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>8199</b> IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme Auto Accident Immediate</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8254</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>6:PM 10-20-68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>		21f. LOCATION Street or R.F.D. No. <b>Rt-225-Near Ironsides Md</b>		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-21-68</b>		
EXAMINER'S NAME (Type) <b>James E. Andrews MD</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Bapt. Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Charles Co., Md.</b>		
24. FUNERAL DIRECTOR <b>Montgomery Bros 719 Kennedy St NW</b>				25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE 		

14343

RECEIVED

880 55700

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print)										2a. DATE KNOWN OF DEATH		2b. HOUR					
Kenneth M. Slater										10-5-68		8-AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		Negro		8/1/46		22 YRS.		MONTHS DAYS		HOURS MIN.		10-5-68		8AM			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Wash. D.C.				USA								Charles					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Glasva Md				RT 301													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
D. C.				Washington				YES <input type="checkbox"/> NO <input type="checkbox"/>				2311 Allamont Pl. SE					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
Ernest William Slater				Helen B. Holland													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
				217-44-3947				Teresa Ann Slater				Wash, D.C. 2311 Allamont Pl. S.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:												Immediate					
IMMEDIATE CAUSE (a) <u>Injuries Multiple Extream</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>S Auto Accident</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
8254																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
				1;30 P.M. 19				Auto Accident									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Highway				Rt-301-Maryland Glasva Charles County									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED					
				James E. Andrews MD								10-5-68					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				10-8-68		St. Thomas Cemetery, Branchville, Md.											
24. FUNERAL DIRECTOR				ADDRESS				25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Mattell Adams				Aquasco, Md.				DATE OCT 11 1968		Charles Judge							

14343

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

FOR THE  
UNITED STATES





# FOR STATE HEALTH DEPT.

any delay is  
18. Give Pages 1, 2, and 3 to  
Office along with form PM3. Page  
Department of  
1. File pages 1 and 2 with the  
2. Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

14335										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14344																													
1. DECEASED NAME (Type or Print) <i>CHRISTIAN E. SMITH</i>															2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>10</i> Day <i>28</i> Year <i>1968</i>															2b. HOUR <i>12</i> M.																			
3. SEX <i>M</i>					4. RACE <i>W</i>					5. DATE OF BIRTH <i>2-15-1857</i>					6. AGE (in years last birthday) <i>110</i> MONTHS <i>11</i> DAYS <i>15</i> HOURS <i>12</i> MIN.					7c. DATE PRONOUNCED DEAD Month <i>10</i> Day <i>28</i> Year <i>1968</i>					2d. HOUR <i>12</i> M.																								
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Charles</i> Md.																								
10. CITY OR TOWN OF DEATH <i>Tacoma</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Edna Laplata</i>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Printer</i>										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>										13b. COUNTY <i>Wash</i>										13c. CITY OR TOWN <i>Wash</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>1624 27th St SE</i>																			
14. FATHER'S NAME First <i>Adolph</i> Middle <i>Smith</i> Last <i>Smith</i>										15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>M</i> Last <i>Holfe</i>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>										16b. SOCIAL SECURITY NO. <i>578-34-591A</i>					17. INFORMANT <i>Katherine Smith</i> ADDRESS <i>Wife</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>0-28-68</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i>																																																	
19a. DATE OF OPERATION															19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE <i>E J ESELEN</i> M.D.															CHIEF MEDICAL EXAMINER <input type="checkbox"/>															22b. DATE SIGNED <i>10-28-68</i>																			
EXAMINER'S NAME (Type) <i>E J ESELEN</i>															ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>															DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>Oct 31-1968</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>										23d. LOCATION (City or Town) (County) (State) <i>Waldorf Maryland</i>																			
24. FUNERAL DIRECTOR <i>Simmons Bros</i>															ADDRESS <i>1661 Bond Ave Rd SE WASH DC</i>															25a. REC'D BY REGISTRAR DATE <i>OCT 30 1968</i>										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

14844

RECEIVED 30 JAN 1954

RECEIVED 30 JAN 1954

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14336						14345					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last JOHN DANIEL SWANN THOMAS						Month Day Year October 29, 1968			5 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negro		December 1915		52 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A				Charles Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
La Plata			Physicians Memorial Hospital			Farmer			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTRY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Charles		Bel Alton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last Lee Hawkins			First Middle Last Mary Ella Swann								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			218-24-1059		Mr. Howard Townshead - Bel Alton, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Long Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Emphysema</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Refractory Asthma</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)											
241X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<u>E.J. Edelen</u>									10-29-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
E.J. Edelen, M.D.						La Plata, Maryland					
23a. BURIAL, CREMATION, or other disposition			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			10/31/1968		St. Ignatius Cemetery		Chapel Point, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Arehart Funeral Home, Inc.-La Plata, Md.						DATE NOV 4 1968			<u>Charles Judge</u>		

14345

GENERAL ORDER

1950

JOHN L. LANE, JR.

October 2, 1950

December 1950

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Physical examination report

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14337

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14346

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year				2b. HOUR	
JOHN		C.		THOMPSON						12:pm			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	001	8-15-25		43 YRS.		MONTHS		DAYS		Month		12:pm	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MARYLAND		U.S.A.				Charles							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
LaPlata		Physicians Memorial											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Md.		Charles		Port Tobacco				Port Tobacco, Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JERAY		THOMPSON		UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
				GEOGINAN THOMPSON, WIFE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Peritonitis													
965X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) bullet wound of abdomen													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
981X Bullet wound of the neck													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				8:30 P.M. 10 20 68				Subject involved in argument, was shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
				Store				McConchies Store, McComchie Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				October 21, 1968					
Edward F. Wilson, M.D.				ADDRESS (Street, city, town, or county)									
23a. BURIAL-CREATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
				10/29/68				St. Catholic					
								23d. LOCATION (City or Town) (County) (State)					
								LA Plata MD.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
BERRY'S FUNERAL HOME				DATE				OCT 29 1968					
LA MONAGLY MARYLAND								J Charles Judge					



14846

Oct 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14338

14347

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles County		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 30-Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial		d. STREET ADDRESS Rt 1 Box 14		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Carlin Warder		4. DATE OF DEATH 10-8-68		5. SEX Male	
6. COLOR OR RACE W-US		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-16-1871	
9. AGE (In years last birthday) 97 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Danville Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Warder		14. MOTHER'S MAIDEN NAME Vandelia Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-2553		17. INFORMANT John C. O'Grady	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aging Process (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Indefinite Indefinite		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10-7-68, 19__, to 10-8-68, 19__, that (I) (we) last saw the deceased alive on 10-8-68, 19__, and that death occurred on 10-8-68, 19__, from the causes and on the date stated above.		22a. SIGNATURE James E. Andrews M.D.	
22b. DATE SIGNED 10-9-68		22c. PHYSICIAN'S NAME (Type) James E. Andrews		22d. ADDRESS Indian Head Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-11-68		23c. NAME OF CEMETERY OR CREMATORY CHRIST CH. CEM.	
23d. LOCATION (City, town or county) (State) ACCOCKEEN, MD.		24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR OCT 14 1968	
25b. REGISTRAR'S SIGNATURE J Charles Judge					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14339

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14348

1. DECEASED-NAME (Type or Print) <b>CLAUDE ELIAS Welty</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>10 23 1968</b>			2b. HOUR <b>10 41 P</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>May 12, 1913</b>	6. AGE (in years last birthday) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>23</b> Year <b>68</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b> Md.			
10. CITY OR TOWN OF DEATH <b>Taneytown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sign Adv.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8 Cemetery St.</b>	
14. FATHER'S NAME First <b>Harry</b> Middle <b>C.</b> Last <b>Welty</b>			15. MOTHER'S MAIDEN NAME First <b>Clara</b> Middle <b>Bohn</b> Last <b>Bohn</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-10-6152</b>		17. INFORMANT <b>Mrs. Catherine Welty, Taneytown, Maryland</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self inflicted bullet wound</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>of head</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10-23-68</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976X</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>9 10-23 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Shot self @ 3 1/2 Revolver</b>					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Kidderberg Hotel</b>		21f. LOCATION Street or R.F.D. No. <b>Taneytown</b>		City or Town <b>Md</b>		State <b>Charles</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>E.J. EDELEN</b>		M.D. <b>172</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10-23-68</b>	
EXAMINER'S NAME (Type) <b>E.J. EDELEN</b>		ADDRESS (Street, city, town, or county) <b>172</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace Reformed Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Taneytown, Carroll, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son</b>				ADDRESS <b>Taneytown, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

14348

RECEIVED DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14340											
14349											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>WILLIAM ALLISON WENK</b>						2a. DATE OF DEATH <b>October 31</b> Year <b>1968</b>			2b. HOUR <b>5:30</b> P. M.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 7, 1912</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>La Plata, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Charles</b>			Md.		
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Book keeper</b>			12b. BUSINESS OR INDUSTRY <b>Construct</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>La Plata</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>William H. Wenk</b> Middle <b>Wenk</b> Last <b>Wenk</b>				15. MOTHER'S MAIDEN NAME First <b>Elsie</b> Middle <b>Lucas</b> Last <b>Lucas</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Lewis Tippet-Waldorf, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Hyperpyrexia</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of pancreas &amp; metastasis</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION <b>12 Oct 68</b>											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Explanatory - tumor pancreas</b>											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>September 1968</b> to <b>31 Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>31 Oct 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Arthur O. Woody, MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. DATE SIGNED <b>Nov 68</b>											
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD</b>											
22e. ADDRESS <b>LA PLATA, MARYLAND 20646</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE <b>11/4/1968</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Shilo M.E. Cemetery</b>											
23d. LOCATION (City or Town) (County) (State) <b>Bryans Road, Maryland</b>											
24. FUNERAL DIRECTOR ADDRESS <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>											
25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>											
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



THE OFFICE OF DEATH

UNITED STATES

DEPARTMENT OF HEALTH

AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

AND STATISTICS

WASHINGTON, D.C.

20540-0100

FORM 100-1

RECEIVED

DATE

TIME

BY

NAME

ADDRESS

CITY

STATE

ZIP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14341

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14350

1. DECEASED-NAME (Type or print) First Middle Last <i>Sarah R. Wiekiser</i>			2a. DATE OF DEATH Month Day Year <i>10 16 68</i>			2b. HOUR M <i>3A</i>							
3. SEX <i>F.</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>June 20 1914</i>		6. AGE (In years last birthday) <i>54</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i> Md.							
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> COUNTY <i>Prince Georges</i>			13b. CITY OR TOWN <i>Hyattsville</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
14. FATHER'S NAME First Middle Last <i>Julian Blacklock</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth Matthews</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218 18-8574</i>		17. INFORMANT Address <i>Mrs. Victoria Mitchell, La Plata, Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Acidosis</i> 2509 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2608 DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-5-68</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Cirrhosis of Liver</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>10-15-68</i> , to <i>10-16-68</i> , that (I) (we) last saw the deceased alive on <i>10-16-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>E. J. Edeken</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10-17-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Edward J. Edeken</i>						22e. ADDRESS <i>La Plata, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>Oct. 18, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Memorial</i>			23d. LOCATION (City or Town) (County) (State) <i>Waldorf, Chas. Md.</i>					
24. FUNERAL DIRECTOR <i>The Hunt Funeral Home</i>			ADDRESS <i>Waldorf, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>OCT 22 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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